To: Christine Kaufmann

From: Christina Goe, General Counsel

Cc: Monica Lindeen, Commissioner

Date: August 30, 2011

Re: HOW TO AVOID ANTI-TRUST ISSUES THAT ARISE IN CONNECTION WITH THE CREATION OF MEDICAL HOMES

Assumption: The development of a medical home payment model that is consistent across payers may require that health plans agree to collaborate in order to coordinate their payment policies. This collaboration could interfere with competition between health insurers and may result in violations of anti-trust laws. This collaboration among competitors may be viewed as illegal restraint of trade under section one of the Sherman Act, which prohibits "combination, contract or conspiracy in restraint of trade or commerce." ***However, collaboration may only be a problem if competitors agree to set prices. Agreeing on a payment model should avoid most problems.***

Caveat: This memorandum is meant to provide a brief overview of possible issues and solutions, but it is not a definitive legal opinion regarding the legality of any particular course of action with regard to state or federal antitrust laws. Most of the information and examples contained in the memorandum were obtained from a legal treatise on this topic from the George Washington University School of Public Health and Health Services entitled, "Health System Reform and Anti-Trust Law—The Antitrust Aspects of Health Information Sharing by Public and Private Health Insurers," by Burke, Cartwright-Smith, Pereira, and Rosenbaum.

Potential Solution: Instead of the "State Action Immunity Doctrine," which was discussed in the previous memorandum, another approach would be to proceed with the development of a pilot payment model that did not involve setting prices. Activities that involve convening stakeholders, providing historic cost and quality outcomes, presenting information on innovations in health care organization and payment, educating and informing interested parties and providing technical support to test payment and delivery innovations appear to raise no antitrust problems, as long as there is no attempt to control the price in a particular geographic region or product market.

Horizontal price-fixing (including establishing minimum and maximum prices), group boycotts, bid rigging and market-allocation agreements are considered *per se* illegal. *Per se* determinations must be avoided. "Conscious parallelism" is one anti-trust safety zone that should avoid a per se determination, in addition to the state-action doctrine. A

pattern of uniform business conduct among competitors is not in and of itself a violation of anti-trust laws, as long as no "meeting of the minds" occurred with regard to actual implementation and roll-out related to the setting of price or other competitively – sensitive terms. Adequate safeguards must be built in to assure there is no agreement on pricing.

Anti-trust "safety zones" are discussed in guidelines issues by the United States Department of Justice and the Federal Trade Commission in 1996: *1996 Statements of Antitrust Guidelines for Collaborations Among Competitors.* Statement 4 establishes an "antitrust safety zone," which allows providers to collectively give purchasers "underlying medical data that may improve purchasers' resolution of issues relating to the mode, quality or efficiency of treatment" and also "standards for patient management developed to assist providers in clinical decision-making." However, this sharing of "outcome data" cannot be used by providers to "coerce" purchasers' decision-making by boycotting a plan that does not adhere to the provider's joint recommendation.

Statements 5 and 6 allow competing providers to give payers information about price or other aspects of reimbursement, such as episode-of-care cost determinations and also to participate in pricing surveys conducted by unrelated third parties, without raising significant antitrust concerns.

Collaboration between insurers and physicians who agree to test a "medical home model" approach to physician payment that would involve basic clinical fees plus a monthly care coordination fee does not appear to violate antitrust law. The parties agree that they will share data on clinical care outcomes and transmit to a third party for analysis. The group agrees on outcomes they will monitor over time. As long as the insurers do not agree to set the fee or bonus amount, anti-trust law should not not violated. However, insurers may not agree on fees or, for instance the amount of incentive payments based on previously agreed to performance measures. *[See Burke, et.al.]*

How to achieve the solution: The approach taken in Pennsylvania may work in Montana. However, some executive action occurred there, allowing the state action doctrine to be invoked for a limited piece of the project. Such executive action may not be possible in Montana without additional statutory authority. The Pennsylvania governor took the following steps:

- Created a commission to develop a medical home
- Issued an executive order detailing specific duties of the commission, which included working with insurers and providers to develop a reimbursement model and to construct common performance and outcome measures
- A third party aggregated data for the group

- The state action doctrine was invoked by the executive order which authorized the assessment of a fee on payers for the limited purpose of reimbursing the providers for the cost of converting to a different payment model
- Minimized risks by not touching contracts between payers and providers,
- The fees were assessed by the government entity so that the payers were not privy to the payment information from their competitors

Pennsylvania avoided negotiations about the base payment rate by analyzing the cost of transforming the payment model and the provision of health care in pilot projects in other states. The state then set an aggregate reimbursement level to be divided among providers based on that analysis. *[See "Navigating Antitrust Concerns in Multi-payer Initiatives"—AcademyHealth Issue Brief]* Pennsylvania also analyzed legal issues, particularly antitrust issues, at every step of the process.

Overall, the recommended approach is to avoid antitrust exposure by sticking to activities that would not restrain trade. This would involve an incremental approach in developing a payment model similar to that described above without setting prices for any of the components. Later on, gaining authority to issue an executive order may allow the state to assist in setting certain fees, similar to what Pennsylvania has done. The insurance commissioner can create an advisory council under Mont. Code Ann. § 2-15-122 to study the creation of a medical home payment model, without the involvement of the governor because she is a state-wide elected official. Advisory councils may furnish advice, gather information and make recommendations, but may not administer a program or set policy. [Mont. Code Ann. § 2-15-102 (1)] Therefore, if a pilot were to be actually launched, a separate working group might be necessary, unless executive authority is obtained or later identified.